Otsuka

Otsuka-people creating new products for better health worldwide

ASSURE™

Helping to clear the path to treatment

Dear Health Care Provider:

We have provided this **sample Letter of Medical Necessity** outlining support for coverage of **<PRODUCT® (generic)>.** Use of this document does not guarantee assistance in the Payer's review of a Letter of Medical Necessity for the medication for your patient.

To use this letter, please copy the text from page 2 and paste it onto your office letterhead. Be sure to replace all bolded and bracketed text with the appropriate patient-specific information before forwarding your customized letter to your patient's insurance provider. If the provided fields do not accurately reflect your practices, please modify them to represent your particular circumstances.

Tips for completing the disease and medical history fields:

- Include specific diagnosis codes where appropriate
- List previous therapy, length of therapy, and outcomes (i.e., specify reasons for unsuccessful results)
- Clearly state the rationale for the recommended therapy and why it is appropriate for your patient

Tips for completing the enclosed materials field:

- List and enclose documents that support your rationale for the recommended therapy:
  - Summary of patient's medical records
  - Journal articles
  - Copies of medical correspondence
  - Specific information about the recommended drug or procedure (Package Insert, FDA approval letter, treatment guidelines compiled by professional physician organizations)
- Be sure to include all the listed documents with the letter when you send it to your patient's insurance provider

We hope you find this **sample Letter of Medical Necessity** to be a valuable resource to your practice.

Sincerely,

Otsuka America Pharmaceutical, Inc.

Otsuka America Pharmaceutical, Inc.
508 Carnegie Center Drive • Princeton, NJ 08540 • Main: 609-524-6788 • www.otsuka-us.com

<Date>

<Name of insurance company>
<Insurance street address>
<City, state, ZIP code>

RE: Appeal for **<Patient Name>**
Member ID: **<Patient ID number>**
Date of Birth: **<Patient date of birth>**
Group Number: **<Patient group number>**

Dear **<insurance contact name>:**

I am writing this **Letter of Medical Necessity** on behalf of **<Patient Name>** which documents the clinical rationale for **<PRODUCT® (generic)>** and provides information about the patient's medical history and treatment.

<Patient Name> is a/an **<Age>**-year old **<Male/Female>** who has been treated for **<disease>** since **<Date>**. **<Provide a brief medical history emphasizing the most recent events that directly influence your decision to recommend the necessary therapy**>.

I have also included materials (enclosure list below) supporting the use of **<PRODUCT®>** to treat **<disease>** in **<Patient Name>.**

If you have any questions regarding my patient's medical necessity for **<PRODUCT® >** please do not hesitate to contact me. Thank you in advance for your prompt attention to this matter.

Sincerely,

<Treating Provider Name>